COX BEHAVIORAL HEALTH GROUP LLC

Screening and Intake – *Adult*

Name		Agency ID#
Date of Birth	Age	Email Address:
Race / Ethnicity A. Are you Hispanic or Latino? ☐ yes ☐ no If yes, country/countries of origin: _____	B. ☐ Asian ☐ American Indian ☐ Black ☐ Caribbean ☐ Haitian ☐ Hawaiian / Pacific Islander ☐ White ☐ Other: _____	
Gender ☐ male ☐ female ☐ other	Marital Status ☐ single ☐ married ☐ divorced ☐ widowed	
Address		
City	State	Zip
Phone	Alternate Phone	
Emergency Contact	Relationship	
Address		
City	State	Zip
Phone	Alternate Phone	
Guardian ad Litem / Conservator / Representative Payee		
Agency	Phone	
Current Housing ☐ own ☐ rent ☐ lives with _____ ☐ shelter ☐ no residence ☐ institution / facility _____ (proposed date of release: _____)		
Employment ☐ F/T ☐ P/T ☐ unemployed, looking ☐ unemployed, not looking ☐ disabled ☐ other		
Household Financial Resources income: _____ ☐ biweekly ☐ monthly ☐ annually		
Income Sources ☐ employment of _____ ☐ SSI / SSDI ☐ other		
Insurance	Entitlements ☐ AFDC / Food Stamps ☐ other	
Primary Care Physician	Hospital	
Referral ☐ DOC ☐ DCF ☐ school ☐ self / parents ☐ physician ☐ other		
Referral Contact	Phone	
Eligible for CA Services ☐ yes ☐ no	Reasons for Ineligibility	

Reasons for Referral (referral source)
Reasons for Referral (client)
Appointment Set date: _____ time: _____ appointment with: ___ _____
Refer to Cox Behavioral Health Group LLC ☐ Assessment ☐ Outpatient Counseling ☐ Prevention ☐ Case Management ☐ Other Services
Refer to Outside Services ☐ Residential Program ☐ Crisis Stabilization ☐ Medical Care ☐ Independent Psychiatrist ☐ Housing Assistance ☐ FACT Team Services ☐ Detoxification Program ☐ Entitlements Assistance ☐ Other

Signature	**Date**

date	time from/to	service	Note: (comment of progress or lack of progress related to screening, intake, and assessment services, including behavior, affect and mental status); signature and credentials

service: CM – Case Management; I/S – Intake and Screening; RF – Referral